

Part B URN # \_\_\_\_\_  
Client Part C # \_\_\_\_\_

**KHCCP**  
**CLIENT INTAKE REPORT**

**Date:** \_\_\_\_\_

***DEMOGRAPHIC TAB:***

**Name:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Last) (First) (MI)

**Preferred name you want to be called:** \_\_\_\_\_

**Gender:** ☐ Male ☐ Female ☐ Transgender (☐ Male to female ☐ Female to male)  
☐ Unknown

**Marital Status:** ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Partnered ☐ Widowed

**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

**Race:** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander  
☐ American Indian / Alaskan Native ☐ Unknown

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SS#:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Mailing address (if different)**

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Primary Telephone #:** ( ) \_\_\_\_ - \_\_\_\_ **Alternate Phone #** ( ) \_\_\_\_ - \_\_\_\_

**May we contact you by phone?** ☐ Yes ☐ No **By mail?** ☐ Yes ☐ No

**Country of Birth:** \_\_\_\_\_ **Residency Status:** \_\_\_\_\_

**Education:** ☐ High School ☐ College ☐ Vocational School ☐ Other ☐ GED  
☐ Check if you can read ☐ Check if you can write

**Highest grade completed:** \_\_\_\_\_

**Do you need an interpreter:** ☐ Yes ☐ No **Language:** \_\_\_\_\_

**Date of HIV Diagnosis:** \_\_\_\_\_ **Date of AIDS Diagnosis:** \_\_\_\_\_

**Risk Factor for Transmission:**

☐ MSM ☐ Injection Drug Use ☐ Blood Transfusion ☐ Heterosexual contact  
☐ Perinatal Transmission ☐ Unknown ☐ Other: \_\_\_\_\_

**Was partner notification conducted?** ☐ Yes ☐ No

If yes, when \_\_\_\_\_

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***SERVICES TAB***

**Program Enrollment Date:** \_\_\_\_\_

(Date should reflect when all documentation is obtained)

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***ANNUAL REVIEW TAB-***

***ANNUAL SUB-TAB:***

**Do you have Medical Insurance?** ☐ Yes ☐ No

If yes, identify insurance carrier:

**Private Company:** \_\_\_\_\_

Does your insurance cover any cost of your medication? ☐ Yes ☐ No

**Identification #:** \_\_\_\_\_ **Group # :** \_\_\_\_\_

**Medicaid #:** \_\_\_\_\_ **Medicare #:** \_\_\_\_\_

**Medicare Part D:** Yes \_\_\_\_ No \_\_\_\_ **Plan Name:** \_\_\_\_\_

If not, are you enrolled in any programs that do assist you with medications? ☐ Yes ☐ No

Describe: \_\_\_\_\_

**Who referred you to KHCCP?** \_\_\_\_\_

**Housing / Living Arrangements**

<input type="checkbox"/> Rent/Own housing	<input type="checkbox"/> Live with family (spouse/parents/partner)
<input type="checkbox"/> Living with friends	<input type="checkbox"/> Homeless (Emergency shelter)
<input type="checkbox"/> Homeless (on the streets)	<input type="checkbox"/> Long term care facility/ Assisted living
<input type="checkbox"/> Substance abuse treatment facility	<input type="checkbox"/> Jail/Prison
<input type="checkbox"/> Transitional housing	<input type="checkbox"/> Hotel/Motel

☐ Other \_\_\_\_\_

**Are you employed?** ☐ Yes ☐ No ☐ Full time ☐ Part time

**Name and address of Employer:** \_\_\_\_\_

Phone (    ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_

Are you Disabled: ☐ Yes ☐ No Date of disability: \_\_\_\_\_

**Identify income for all household members:** include legally married spouse, children under the age of 18, any dependents, and anyone who assist with your medical bills.

**Sources of Income Include:**

☐ SSI                      ☐ SSDI                      ☐ Pension                      ☐ TANF  
☐ Alimony                      ☐ Child support                      ☐ VA benefits                      ☐ Employment  
☐ Workman's comp   ☐ Unemployment ins.                      ☐ Other \_\_\_\_\_

Annual Household Income: \$ \_\_\_\_\_

Number in household: \_\_\_\_\_

**List names, ages, and relationship to client:**

Name	Age	Relationship	Knows Status	Supportive
_____	_____	_____	Yes / No	Yes / No
_____	_____	_____	Yes / No	Yes / No
_____	_____	_____	Yes / No	Yes / No
_____	_____	_____	Yes / No	Yes / No
_____	_____	_____	Yes / No	Yes / No
_____	_____	_____	Yes / No	Yes / No
_____	_____	_____	Yes / No	Yes / No

**Do you have other individuals (not listed above) who provide you with support?**

If yes, who? \_\_\_\_\_

Do any these people help pay your medical expenses? ☐ Yes ☐ No

**QUARTERLY SUB-TABS**

**SUBSTANCE ABUSE**

Substance Abuse Hx: Yes \_\_\_ No \_\_\_ Last used: \_\_\_\_\_

Currently in treatment: Yes \_\_\_ No \_\_\_ Explain: \_\_\_\_\_

Do you smoke cigars or cigarettes? ☐ Yes ☐ No If yes, how many per day? \_\_\_\_\_

How many days in the last month have you had an alcoholic drink? ☐ 0-5 ☐ 5-15 ☐ >15  
 How many drinks do you consume on the days you drink? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ >6  
 Have you ever used/ currently use any of the following?

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Methamphetamines  
☐ Methadone ☐ Ecstasy ☐ Other: \_\_\_\_\_

If yes, when was the last time you used? \_\_\_\_\_

Have you ever been in treatment for alcohol and/or substance use? ☐ Yes ☐ No

If yes, where did you receive treatment and when? \_\_\_\_\_

Do you feel you would benefit from a referral to a treatment program? ☐ Yes ☐ No

**Do you currently see a counselor?** ☐ Yes ☐ No

**Counselor's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referred for Substance Abuse Treatment:** Yes / No

### **MENTAL HEALTH**

**Mental Health Hx:** Yes \_\_\_\_ No \_\_\_\_ Last episode: \_\_\_\_\_

Currently in treatment: Yes \_\_\_\_ No \_\_\_\_ Explain: \_\_\_\_\_

**Have you ever been hospitalized for mental health issues?** ☐ Yes ☐ No

**If yes, when and why?** \_\_\_\_\_

**Are you currently taking any mental health medications?** ☐ Yes ☐ No

**Have you ever been prescribed any mental health medications?** ☐ Yes ☐ No

If yes to either question, when and what medication(s)?

**Over the last 2 weeks how often were you bothered by the following:**

**Scoring:** Several Days = 1 Half the Days = 2 Everyday = 3

		Not at all	Several days	Half the days	Everyday
1.	Little interest or pleasure in doing things				
2.	Feeling down, depressed, or hopeless				
3.	Trouble falling or staying asleep, or sleeping too much				
4.	Feeling tired or having little energy				
5.	Poor appetite or overeating				
6.	Feeling bad about yourself-or that you're a failure or have let yourself or your family down				
7.	Trouble concentrating on things, such as reading or watching TV				
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
9.	Thoughts that you would be better off dead, or of hurting yourself in some way				

Total Score: \_\_\_\_\_

10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
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**Do you feel you would benefit from a referral to a mental health treatment program?**☐ Yes ☐ No**Do you currently see a counselor?** ☐ Yes ☐ No**Counselor's Name:** \_\_\_\_\_**Phone:** \_\_\_\_\_**Referred for Mental Health Treatment:** Yes / No**LEGAL ISSUES****Have you ever been incarcerated?** ☐ Yes ☐ No **Date and location?** \_\_\_\_\_**Do you have any pending legal charges/issues?** ☐ Yes ☐ No **Explain:** \_\_\_\_\_**Do you have a parole/probation officer?** ☐ Yes ☐ No If yes, name and contact information: \_\_\_\_\_**DOMESTIC VIOLENCE****During the last 12 months, has ANYONE threatened you, followed you, controlled your activities or in any other way made you feel unsafe?**☐ Yes ☐ NoIf yes,  
when? \_\_\_\_\_**During the last 12 months, has ANYONE pushed, shoved, slapped, hit, kicked or otherwise physically hurt you?**☐ Yes ☐ NoIf yes,  
when? \_\_\_\_\_**During the last 12 months, has ANYONE forced or coerced you into sexual activities?**☐ Yes ☐ NoIf yes,  
when? \_\_\_\_\_

**Do you feel safe now?** ☐ Yes ☐ No

**If no, explain** \_\_\_\_\_

**Do you feel you would benefit from a referral to a counselor?** ☐ Yes ☐ No

***ENCOUNTERS TAB***

**Current Medications:** (Please include all medications and supplements)

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**Do you have any problems taking your medications?** ☐ Yes ☐ No

If yes, Describe \_\_\_\_\_

**Have you *ever* been diagnosed or treated for the following:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> CMV                          | <input type="checkbox"/> Cervical abnormalities | <input type="checkbox"/> Candida/ oral               |
| <input type="checkbox"/> Candida/ vaginal             | <input type="checkbox"/> Cryptosporidium        | <input type="checkbox"/> Hepatitis A__ B__ C__       |
| <input type="checkbox"/> Herpes simplex               | <input type="checkbox"/> Herpes zoster          | <input type="checkbox"/> Histoplasmosis              |
| <input type="checkbox"/> Kaposi Sarcoma               | <input type="checkbox"/> Lymphadenopathy        | <input type="checkbox"/> Arthritis                   |
| <input type="checkbox"/> Pneumocystis                 | <input type="checkbox"/> STDs                   | <input type="checkbox"/> Toxoplasmosis               |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> Heart Disease                | <input type="checkbox"/> Depression/ anxiety    | <input type="checkbox"/> GERD (reflux/ heartburn)    |
| <input type="checkbox"/> Colon problems or procedures |   | <input type="checkbox"/> Skin Disorders              |
| <input type="checkbox"/> Prostate problems            | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Positive PPD (TB skin test) |
| <input type="checkbox"/> Other: _____                 |   |  |

**Which of the following health problems do you currently have?**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Cough                          | <input type="checkbox"/> Diarrhea                                   | <input type="checkbox"/> Fever, chills  | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Rashes                                     | <input type="checkbox"/> Weight loss    | <input type="checkbox"/> Depression    |
| <input type="checkbox"/> Shortness of breath            | <input type="checkbox"/> Seizures                                   | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Weakness      |
| <input type="checkbox"/> Problems chewing or swallowing | <input type="checkbox"/> Nausea                                     | <input type="checkbox"/> Vomiting       |  |
| <input type="checkbox"/> Pain: location _____           | <input type="checkbox"/> Numbness or tingling in your hands or feet |   |  |
| <input type="checkbox"/> Other _____                    |   |   |  |

**Have you discussed these health problems with your doctor?** ☐ Yes ☐ No

Most recent CD4 results: CD4 absolute: \_\_\_\_\_ Date: \_\_\_\_\_

CD4 percent: \_\_\_\_\_ Date: \_\_\_\_\_

Most recent viral load results: VL: \_\_\_\_\_ Date: \_\_\_\_\_

**Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

Have you had any ***unexplained weight loss*** within the last 3 months? ☐ Yes ☐ No

If yes, how many pounds? \_\_\_\_\_

How many meals do you eat on an average day? ☐ One ☐ Two ☐ Three or more

Are you able to get food? (food stamps, food pantry, vouchers) ☐ Yes ☐ No

Do you have a clean, appropriate place to keep food? ☐ Yes ☐ No

Are/have you been prescribed a nutritional supplement by your health provider? ☐ Yes ☐ No

When? \_\_\_\_\_

If yes, what is the product and directions: \_\_\_\_\_

Do you feel you would benefit from a referral to a dietician? ☐ Yes ☐ No

### FAMILY HISTORY/ STATUS

**Is there a family history of any of the following:**

☐ Asthma

☐ Hypertension

☐ Diabetes

☐ Heart Disease

☐ Depression/ anxiety

☐ Migraines

☐ Colon problems/procedures

☐ GERD (reflux/ heartburn)

☐ Skin Disorders

☐ Prostate problems

☐ Positive PPD (TB skin test)

☐ Cancer

☐ Other: \_\_\_\_\_

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### Family Name and Education Level:

Father's Education: \_\_\_\_\_

Mother's Education: \_\_\_\_\_

Sibling's Education: \_\_\_\_\_

Sibling's Education: \_\_\_\_\_

Sibling's Education: \_\_\_\_\_

Sibling's Education: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Grade: \_\_\_\_\_

### ***REFERRALS TAB***

**Referrals Needed:** Check all that apply

☐ Housing

☐ Food/Nutrition

☐ Clothing

☐ Medication

☐ Medical

☐ Dental

☐ Mental Health

☐ Substance Abuse

☐ Transportation

☐ Employment

☐ Family Issues

☐ Legal

☐ KADAP

☐ KHICP

☐ Medicare

☐ Medicaid

☐ Social Security

☐ Hospital Indigent Program

☐ Private Insurance

☐ Education

☐ Vocational Rehab ☐ Domestic Violence Program

☐ Other: \_\_\_\_\_

***TX INFORMATION TAB:***

**Emergency Contact Person:** \_\_\_\_\_

**Phone:** (    ) \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Aware of Diagnosis?** ☐ Yes ☐ No

**Primary Care Physician:** \_\_\_\_\_ **Phone:** (    ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**HIV/AIDS Provider:** \_\_\_\_\_ **Phone:** (    ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Phone:** (    ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Phone:** (    ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**Vision** \_\_\_\_\_ **Phone:** (    ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone:** (    ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Care Coordinator Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**KHCCP Region:** \_\_\_\_\_

**Additional space:** \_\_\_\_\_

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